

§ 424.32 Basic requirements for all claims.

(a) A claim must meet the following requirements:

(1) A claim must be filed with the appropriate intermediary or carrier on a form prescribed by CMS in accordance with CMS instructions.

(2) A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD-9-CM.

(3) A claim must be signed by the beneficiary or the beneficiary's representative (in accordance with § 424.36(b)).

(4) A claim must be filed within the time limits specified in § 424.44.

(5) All Part B claims for services furnished to SNF residents (whether filed by the SNF or by another entity) must include the SNF's Medicare provider number and appropriate HCPCS coding.

(b) The prescribed forms for claims are the following:

CMS-1450—Uniform Institutional Provider Bill. (This form is for institutional provider billing for Medicare inpatient, outpatient and home health services.)

CMS-1490S—Request for Medicare payment. (For use by a patient to request payment for medical expenses.)

CMS-1500—Health Insurance Claim Form. (For use by physicians and other suppliers to request payment for medical services.)

CMS-1660—Request for Information-Medicare Payment for Services to a Patient now Deceased. (For use in requesting amounts payable under title XVIII to a deceased beneficiary.)

(c) *Where claims forms are available.* Excluding forms CMS-1450 and CMS-1500, all claims forms prescribed for use in the Medicare program are distributed free-of-charge to the public, institutions, or organizations. The CMS-1450 and CMS-1500 may be obtained only by commercial purchase. All other claims forms can be obtained upon request from CMS or any Social Security branch or district office, or from Medicare intermediaries or carriers. The CMS-1490S is also available at local Social Security Offices.

(d) *Submission of electronic claims—(1) Definitions.* For purposes of this paragraph, the following terms have the following meanings:

(i) *Claim* means a transaction defined at 45 CFR 162.1101(a).

(ii) *Electronic claim* means a claim that is submitted via electronic media. A claim submitted via direct data entry is considered to be an electronic claim.

(iii) *Direct data entry* is defined at 45 CFR 162.103.

(iv) *Electronic media* is defined at 45 CFR 160.103.

(v) *Initial Medicare claim* means a claim submitted to Medicare for payment under Part A or Part B of the Medicare Program under title XVIII of the Act for initial processing, including claims sent to Medicare for the first time for secondary payment purposes. Initial Medicare claim excludes any adjustment or appeal of a previously submitted claim, and claims submitted for payment under Part C of the Medicare program under title XVIII of the Act.

(vi) *Physician, practitioner, facility, or supplier* is a Medicare provider or supplier other than a provider of services.

(vii) *Provider of services* means a provider of services as defined in section 1861(u) of the Act.

(viii) *Small provider of services or small supplier* means—

(A) A provider of services with fewer than 25 full-time equivalent employees; or

(B) A physician, practitioner, facility, or supplier with fewer than 10 full-time equivalent employees.

(2) *Submission of electronic claims required.* Except for claims to which paragraph (d)(3) or (d)(4) of this section applies, an initial Medicare claim may be paid only if submitted as an electronic claim for processing by the Medicare fiscal intermediary or carrier that serves the physician, practitioner, facility, supplier, or provider of services. This requirement does not apply to any other transactions, including adjustment or appeal of the initial Medicare claim.

(3) *Exceptions to requirement to submit electronic claims.* The requirement of paragraph (d)(2) of this section is waived for any initial Medicare claim when—

(i) There is no method available for the submission of an electronic claim. This exception includes claims submitted by Medicare beneficiaries and

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situations in which the standard adopted by the Secretary at 45 FR 162.1102 does not support all of the information necessary for payment of the claim. The Secretary may identify situations coming within this exception in guidance.

(ii) The entity submitting the claim is a small provider of services or small supplier.

(4) *Unusual cases.* The Secretary may waive the requirement of paragraph (d)(2) of this section in unusual cases as the Secretary finds appropriate. Unusual cases are deemed to exist in the following situations:

(i) The submission of dental claims.

(ii) There is a service interruption in the mode of submitting the electronic claim that is outside the control of the entity submitting the claim, for the period of the interruption.

(iii) The entity submitting the claim submits fewer than 10 claims to Medicare per month, on average.

(iv) The entity submitting the claim only furnishes services outside of the U.S. territory.

(v) On demonstration, satisfactory to the Secretary, of other extraordinary circumstances precluding submission of electronic claims.

(5) *Effective date.* This paragraph (d) is effective October 16, 2003, and applies to claims submitted on or after October 16, 2003.

[53 FR 6639, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988, as amended at 59 FR 10299, Mar. 4, 1994; 63 FR 26311, May 12, 1998; 63 FR 53307, Oct. 5, 1998; 66 FR 39601, July 31, 2001; 68 FR 48813, Aug. 15, 2003; 70 FR 71020, Nov. 25, 2005; 71 FR 48143, Aug. 18, 2006]

§ 424.33 Additional requirements: Claims for services of providers and claims by suppliers and nonparticipating hospitals.

All claims for services of providers and all claims by suppliers and nonparticipating hospitals must be—

(a) Filed by the provider, supplier, or hospital; and

(b) Signed by the provider, supplier, or hospital unless CMS instructions waive this requirement.

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§ 424.34 Additional requirements: Beneficiary's claim for direct payment.

(a) *Basic rule.* A beneficiary's claim for direct payment for services furnished by a supplier, or by a nonparticipating hospital that has not elected to claim payment for emergency services, must include an itemized bill or a "report of services", as specified in paragraphs (b) and (c) of this section.

(b) *Itemized bill from the hospital or supplier.* The itemized bill for the services, which may be receipted or unpaid, must include all of the following information:

(1) The name and address of—

(i) The beneficiary;

(ii) The supplier or nonparticipating hospital that furnished the services; and

(iii) The physician who prescribed the services if they were furnished by a supplier other than the physician.

(2) The place where each service was furnished, e.g., home, office, independent laboratory, hospital.

(3) The date each service was furnished.

(4) A listing of the services in sufficient detail to permit determination of payment under the fee schedule for physicians' services; for itemized bills from physicians, appropriate diagnostic coding using ICD-9-CM must be used.

(5) The charges for each service.

(c) *Report of services furnished by a supplier.* For Medicare Part B services furnished by a supplier, the beneficiary claims may include the "Report of Services" portion of the appropriate claims form, completed by the supplier in accordance with CMS instructions, in lieu of an itemized bill.

[53 FR 6634, Mar. 2, 1988, as amended at 59 FR 10299, Mar. 4, 1994; 59 FR 26740, May 24, 1994]

§ 424.36 Signature requirements.

(a) *General rule.* The beneficiary's own signature is required on the claim unless the beneficiary has died or the provisions of paragraph (b), (c), or (d) of this section apply.

(b) *Who may sign when the beneficiary is incapable.* If the beneficiary is physically or mentally incapable of signing the claim, the claim may be signed on